I agree, Mr. President. Balancing the budget is good for America, and reducing this deficit is good for America. That is not the issue. That is not what is at stake here because we are going to do that.

The question is, how are we going to do it? Are we going to do it fixated only on the fiscal deficit, or are we also going to think about the spiritual, moral, cultural deficit in this country? Are we also going to think about the investment deficit in this country?

You do not get from here to there in America on an old FAA computer system and call it safe. You do not get from here to there in America on trains that are predestined to crash because we do not invest enough in safety measures for our country. You do not get from here to there in America on roads that were not built in the National Highway System with the commitment of Federal participation. There are hundreds of examples, where responsible action at the Federal level has improved the capacity of this country to provide for its people and to help people provide for themselves.

I am absolutely one who accepts the notion that we have to rethink how we deliver services. I am prepared to shrink the size of Washington. In fact we have been doing that. We will soon have around 200,000 fewer bureaucrats. It is the smallest Government we had since Jack Kennedy was President of the United States. You would not know that from listening to our colleagues. We have had 3 straight years of deficit reduction. And now we will move on to balance the budget, which is what we ought to do.

But Americans are going to ask whether, as we did this, we did it sensibly; whether it is fair; whether we had a vision for what we want the future to be. Americans are going to ask whether or not this document represents an antivision, or a vision. I am confident that, because it represents an antivision, the President of the United States will ultimately veto it, because it is not bipartisan, because it is not reflective of the higher plane of vision of what this country ought to be and what we want it to be.

I yield the floor.

The PRESIDING OFFICER. The Senator from Tennessee is recognized.

MEDICARE

Mr. FRIST. Mr. President, I rise today to join my colleagues who earlier discussed what is truly a historic budget reconciliation that will be coming to the floor in the morning. This is legislation that will balance the Federal budget in 7 years, and that is the issue before us; that will reform welfare, and that is the issue before us; that will save Medicare from bankruptcy, because that is the issue before us; and which will provide much needed tax relief to American families.

The Social Security and Medicare programs were reviewed in a document. The trustees, there were six in all, three of whom were on the Clinton administration's Cabinet, made it very clear that the issue before us in Medicare is to save it from bankruptcy, to save the entire program—not just a part of it, not just one trust fund, but the entire program.

On the first page of the report of the trustees—and, again, the trustees, three of whom are from Clinton's Cabinet—it says very clearly, ''The Federal Hospital Insurance Trust Fund will be able to pay benefits for only about 7 years and is severely out of financial balance in the long range. The trustees believe that prompt, effective and decisive action is necessary.'' And that action we have in this reconciliation package.

On page 13 of this same report it spells it out very clearly that, ''both the hospital insurance trust fund and the supplementary medical insurance trust fund show alarming financial results.'' That is part A and part B; not just part A, as we so often hear from the other side of the aisle.

I continue reading from page 13, ''The HI trust fund continues to be severely out of financial balance and is projected to be exhausted in 7 years. The SMI trust fund [which is part B, the physician part] shows a rate of growth of cost which is clearly unsustainable.''

Again, reading the exact words, these words are from Sanford Ross and David Walker, the two public trustees, ''The Medicare program is clearly unsustainable in its present form.'' Not just the part A trust fund but the Medicare program. Again, we hear from the other side of the aisle we can put another Band-Aid on this program. We can do what we have done in the past and ratchet down a little more on the hospitals, because it is not a crisis. It is not all that urgent. ''We have seen it before over the last 10 years,'' the other side of the aisle says. Yet the trustees say, ''We strongly recommend that the crisis presented by the financial condition of the Medicare trust funds [both funds] be urgently addressed on a comprehensive basis.''

These are the trustees' words. I point that out because, again, we hear every day and several times a day, ''Let us just put another $100 billion into the program and that will take care of it for another couple of years.'' No, the trustees say we need to address part A, and part B, hospitals and doctors, the program overall, and not just one aspect of that program.

So, we make the case. The trustees have made the case that Medicare is going bankrupt if we do nothing. The American people did not know that 1 year ago, or even 8 months ago. Now our senior citizens recognize that. Our individuals with disabilities recognize that. And they recognize that we are going to have to change the system, bring it up to date, to 1995 standards. It is a good program. As a physician I have seen that it has cared for millions and millions of our senior citizens in an effective way. But, as the trustees said, it cannot be sustained. It needs to be modernized.

We pointed out again and again that we are going to increase spending in the Medicare program. Just a few moments ago we heard, when you adjust it on a per beneficiary, or per capita, or per person basis we are really not increasing it. That is not true. On a per capita, per person, per senior citizen, we are spending $4,800 a year this year and that is going to increase next year and that is going to increase the year after that, and increase the year after that to, by the year 2002, just 6½ years from now, we are going to be spending $6,700, almost $2,000 more than we are spending today. And that is not a cut.

It is going bankrupt if we do nothing. We have heard no alternative, reasonable alternative that addresses the overall program from the other side of the aisle.

Second, we are going to increase spending, not cut.

And, third is something that I am most excited about, again because of my past experience as a physician, as one who has taken care of thousands of senior citizens. When I close my eyes I do see faces, individual faces of mothers, of grandmothers, of fathers, of grandfathers, of individuals with disabilities. We cannot just throw more money at the problem, more Band-Aids. We have to strengthen the system.

We have not given enough attention publicly to what we are doing in strengthening this system, in improving it, in giving our seniors and individuals more options that meet their individual needs. That is where we are giving them the right to choose, empowering them to choose a plan which might better meet their needs but at the same time allowing them to keep exactly what they have today if they wish.

Let me refer to this chart, just to explain what I mean by that, how we are strengthening the program. Just focus on the top part of this part. Today we have fee for service, traditional fee for service, where you choose your own physician, you pay your physician in a very direct fashion for the services delivered, and about 91 percent of the 37 million people on Medicare today are in a fee for service system.

About 9 percent of those 37 million people are in an HMO. It is a very limited model. It is a very closed model today, but that is an option for 1 out of 10 of our citizens. On the other hand, in the State of Tennessee there are no HMO's in the Medicare system. Everybody, the number actually in Tennessee of all those 37 million people, for the most part are in just this fee-for-service system.

We are going to hear the plan laid out a little more over the next few days. But what does it do for our senior citizens? As I said, our senior citizens can stay in fee for service, keep their same physician today, not be forced

out of that system at all. Or they can stay in an HMO, if they happen to be there and are pleased with that. But look what we are actually opening up to those senior citizens: A wonderful array of plans that can better meet their individual needs.

If you need a lot of prescription drugs, you are not going to want to be in a fee-for-service system where prescription drugs are not covered. You might want to pick one of these other plans. You do not have to, but you can, for the first time in 30 years in the history of this program.

Medical savings accounts; for the first time a senior citizen can pick a medical savings account or indemnity plan or a preferred provider organization or a point of service plan, or a union-sponsored plan. For the first time, our senior citizens are going to be able to opt for the plan that better meets their needs.

Medical savings accounts—let me just take a few minutes and talk about medical savings accounts, because it is an example of an option that our seniors today have no access to, that, once this bill passes, they will be able to choose if they would like. The use by health consumers of MSA's will change provider behavior—the physician, the hospital—as well as consumer behavior. Why? Because it, if one chooses that, will decrease the role of third-party payers.

It will also increase an individual's awareness of the health care costs. Today, there is really very little incentive for patients to be cost-conscious consumers of health care. On average, every time a patient in America receives a dollar's worth of care, 79 cents is paid by a third party—by an insurance company, or by the Federal Government. Only 21 cents is paid by that patient.

The result is that we have the potential—and I believe grossly—of overconsuming medical services today. Everyone wants it. It is a human tendency. You want it for your mother, your spouse, and your children. Everybody wants the latest, the hottest, the most sophisticated, and, yes, usually the most expensive in whatever medical service it is. It might be the most deluxe hospital room, or it might be getting an MRI scan for a headache, or it might be the latest in nuclear medical imaging. We want the very best. This does play a role in increasing the cost of health care.

Medical savings accounts—which are savings accounts that an individual puts money into and can draw upon for care—will help introduce incentives, marketplace incentives, for most cost-conscious behavior.

MSA's, medical savings accounts, give individuals more choice in the health care market. Our senior citizen cannot join an MSA today in Medicare. It will help stem rising health care costs without decreasing availability or the quality of patient care. It empowers individuals to make prudent, cost-conscious decisions about their health care, about their health care needs, and how to meet those needs. And it will encourage hospitals and physicians to compete for patients on the basis of cost, yes, but also outcomes and quality of care.

There is another important aspect of medical savings accounts, and it is really overlooked almost always by policymakers in Washington; that is, the effect that empowerment of individuals—37 million individuals potentially, although I do not think it will be that—but that empowerment actually changes provider behavior. It changes physician behavior. Doctors, like patients, are accustomed to a system that is not subject to market forces. Since insured patients do not have any incentives to shop around or ask outcome questions or compare medical services, whether it is based on price or outcome, physicians are not rewarded for providing cost-conscious care.

Throughout much of my practice as a heart surgeon and a heart transplant surgeon, I would perform a heart operation, submit the bill, and the bill was paid with no questions asked by the patient.

The PRESIDING OFFICER. If the Senator will suspend, under the rules of morning business we are operating in, Senators are limited to 10 minutes unless the Senator asks unanimous consent.

Mr. FRIST. I ask unanimous consent that I be allowed to continue for 5 minutes.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Mr. FRIST. Mr. President, traditionally no questions have been asked. One day an individual came to see me. He actually needed a heart transplant. He came with a list of transplant centers. He said, ''These are outcomes that I have heard about. What are your outcomes?'' He asked, ''What are your infection rates, and how much do you charge for heart transplants?''

To be honest, nobody had ever come in and asked, ''How much do you charge for a heart transplant?'' What I did was actually turn around and go back to my transplant team, and say, ''Let us see exactly what we charge. Let us be able to answer that question why we charge what we charge as well as look at the outcome data and how our results were compared to other people,'' not only with my own practice and my own transplant team, but the other transplant teams in my center.

I brought them together, and sure enough, we looked at quality standards. We got those out to the community. And, yes, we lowered our prices for how much we would charge for transplantation. Just because of one empowered patient who came forward and asked the right questions, I think we improved quality, we improved care, and we gave more cost-effective care.

Because someone else usually pays the bills, many patients forget that they are consumers. They do not ask providers to be accountable. If one individual can make such a difference, just imagine what impact we can make when we empower thousands of individuals similarly.

Because I strongly believe that empowerment of individuals will help reform—not totally reform the system but help reform, the delivery of health care—I recently introduced a bill, S. 1249, which provides for establishment of a little bit different type of MSA. Under this bill, just to use an example, an employer would deposit up to $2,500 in a tax-free savings account for an employee and would also purchase a catastrophic-type health insurance policy to cover the cost of extraordinary medical expenses. Routine expenses, like eye glasses, annual checkups, possibly prescriptions and dental work would be paid by the employee using that medical savings account. If you did not use all those funds, that medical savings account would accumulate from year to year. Self-employed and uninsured individuals would also be able to establish an MSA link with a low-cost insurance plan under this bill.

Unlike the other MSA proposals introduced in Congress, my bill allows for greater flexibility in benefit design. S. 1249, unlike some of the other more restrictive MSA's, allows managed care companies to offer a low-cost plan based on higher cost sharing rather than just a large, rigid deductible. Restricting plan participation to the size of the deductible may work fine in today's market, but as we learn more and more about how individuals purchase health care services under an MSA, the market may need greater flexibility which can be accomplished under our plan.

Indeed, many insurance plans today have modified their benefit and cost-sharing design over time to alter consumer behavior. Some critics of MSA's are concerned that individuals may forego preventive care to save money. I personally believe that greater control over your health care dollars will encourage more preventive care in this environment.

In my MSA proposal, we would allow a plan to possibly stretch the effect of cost-conscious purchasing by requiring a 50 percent copayment for the first $5,000 of services in a year as opposed to the traditional high deductible plan. My bill would allow this flexibility.

Mr. President, in closing, we, in America, are fortunate to have the absolute highest quality health in the world. When leaders of the world become seriously ill, they do not go to Great Britain or Canada to seek treatment. They come to the United States. While there are those who would like to stifle our technological advances and allow bureaucrats to tell us how much and what kind of health care we can receive, the American people have loudly and clearly rejected this notion.

No one can predict what will happen in medicine over the next 50 years. Over the last 50 years, there have been tremendous changes. The technological advances are simply mind-boggling. The challenge for us in health care is to maintain the highest quality of health care in the world and at the same time to continue to make it available to all Americans, but this can be done only if we change that basic framework through which medical services are consumed.

A medical savings account, again, is not the answer to these problems. But it is an alternative. It is an option which will go a long way to empower individual consumers.

HONORING HARRY KIZIRIAN

Mr. PELL. Mr. President, today the Senate will act on H.R. 1606, legislation to designate the U.S. Post Office Building located at 24 Corliss Street, Providence, RI, as ''The Harry Kizirian Post Office Building.'' I was pleased to join my colleague, Senator JOHN CHAFEE, in cosponsoring the Senate version of the bill, S. 786.

It is a fitting tribute for Congress to name this particular structure after Harry Kizirian because it was the first post office in the United States to use a fully automated sorting system, under Harry's supervision. Harry Kizirian himself is a Rhode Island landmark because of his extraordinary contributions to the United States, to Rhode Island, and to Providence.

When Harry was just 15 years old, his father died, and he went to work part-time as a postal clerk to help support his widowed mother. He then worked his way up through the leadership positions in the Postal Service. After being nominated by former Senator John O. Pastore, Harry was confirmed by the Senate in 1961 as postmaster of Providence, RI, a post he held for more than 25 years.

World War II interrupted Harry's career for a short time. He enlisted in the U.S. Marine Corps after he graduated from Mount Pleasant High School and subsequently became Rhode Island's most decorated marine.

He fought in Okinawa and was shot in battle. He earned the Navy Cross, the Bronze Star with a ''V'', the Purple Heart with a gold star and, finally, the Rhode Island Cross.

After the war, Harry returned to Rhode Island and to his job at the Post Office. In addition to his military service and his work in the Postal Service, he had served on numerous committees and boards in Rhode Island.

Harry served on the board of directors of Butler Hospital, Big Brothers of Rhode Island, the Providence Human Relations Commission, Rhode Island Blue Cross, and Rhode Island Heart and Lung Associations.

He was also a member of the Community Advisory Board of Rhode Island College, the Providence Heritage Commission, the Commission on Rhode Island Medal Honor Recipients, DAV, and the Marine Corps League.

Harry Kizirian's name has become synonymous with the qualities he exemplifies—dedication, loyalty, leadership, and hard work. I am delighted to honor him, not only for his lifetime of service to the Postal Service, but also for his involvement with and commitment to his community. Congratulations, Harry.

U.S. WORKERS NEED MORE PROTECTION UNDER OUR IMMIGRATION LAWS

Mr. KENNEDY. Mr. President, legal immigration within the limits and rules of our immigration laws has served America well throughout our history, and is one of the most important elements of our national strength and character.

Clearly, Congress and the American people today are rightly concerned about illegal immigration. There is broad bipartisan support for effective measures to crack down on this festering problem. But we must be careful to ensure that attitudes toward illegal immigrants do not create a backlash against legal immigrants.

In general, the current laws and policies on legal immigration work well, and we must be hesitant to change them, especially those that give high priority to encouraging family reunification and enabling U.S. citizens to bring their spouses, children, parents and siblings to this country.

But one area of legal immigration that needs reform is in the rules protecting American workers. It has become clear that protections for U.S. workers under current law have not kept pace with changes in the American labor market and the world labor market.

This problem is particularly serious in our laws permitting the entry of temporary foreign workers—the so-called nonimmigrants. Hearings conducted earlier this month by the Senate Subcommittee on Immigration, under the able chairmanship of Senator SIMPSON, have revealed the depth of this problem.

U.S. companies are increasingly outsourcing activities previously performed by permanent employees. More firms are resorting more often to the use of temporary workers or independent contractors as a way of increasing profits and reducing wages and benefits, even though the result is less in-house expertise for the firms.

Often, the workers brought in from outside are U.S. citizens. But increasingly, U.S. firms are also turning to temporary foreign workers. Yet, this little known aspect of our immigration laws includes few protections for U.S. workers.

Current laws governing permanent immigrant workers require employers to try to recruit U.S. workers first. The Department of Labor must certify that efforts for such recruitment have been carried out before an employer can sponsor an immigrant worker. This process has some shortcomings, but it is intended to guarantee that immigrant workers do not displace American workers.

A serious problem is that our laws governing temporary foreign workers contain no such requirement. They are based on the outdated view that because they enter only temporarily, few protections for U.S. workers are required. Current law does not require employers to try to recruit U.S. workers first, and the Department of Labor has little authority to investigate and remedy abuses that arise, such as the underpayment of wages or the use of inadequate working conditions.

As a result, a U.S. firm can lay off permanent U.S. workers and fill their jobs with temporary foreign workers—either by hiring them directly or by using outside contractors.

In one case, a major U.S. computer firm laid off many of its U.S. computer programmers, then entered into a joint venture with an Indian computer firm that supplied replacement programmers—most of whom were temporary workers from India.

While reforms are needed in this area, we must be careful not to throw the baby out with the bath water. Many temporary workers who come here provide unique skills that help the United States to stay competitive in the global marketplace. For example, such workers can bring unique knowledge and expertise to university research programs developing new medical advances and new technologies.

As Congress takes up far-reaching reforms in legal immigration, it is vitally important that we recognize these basic distinctions. Stronger protections for American workers are needed. But they are not inconsistent with preserving an appropriate role for foreign workers with unique skills.

In our subcommittee hearings earlier this month, Secretary of Labor Robert Reich proposed three important changes to our immigration laws on temporary foreign workers. I believe these should receive serious consideration by Congress.

Secretary Reich proposed, first, that these employers should be required to make good faith efforts to recruit U.S. workers first—before seeking the entry of a foreign worker. Second, he proposed that employers who lay off U.S. workers should be precluded from seeking foreign workers in that field for at least 6 months. Third, he proposed that the length of time that temporary foreign workers may remain in the United States be reduced from 6 years under current law to no more than 3 years, in order to reduce the overall number of temporary foreign workers in the country at a given time.

In addition to these three thoughtful proposals by Secretary Reich, the bipartisan Commission on Immigration Reform, chaired by former Congresswoman Barbara Jordan, has recommended that employers who request